

February 10, 2004

## **CDC Issues Interim Recommendations for Enhanced U.S. Surveillance and Testing on Influenza A (H5N1) and SARS**

### **Dear Colleagues**

In response to the recent laboratory confirmed human cases of influenza A (H5N1) in Vietnam and Thailand CDC has issued the following interim recommendations, effective immediately.

Highly pathogenic avian influenza A (H5N1) is classified as a select agent and must be worked with under Biosafety Level (BSL) 3+ laboratory conditions only. Specific BSL3+ conditions include controlled access double door entry with changing room and shower-out facilities. Laboratories working with live H5N1 influenza virus cultures must also be certified by the USDA. The same BSL3+ recommendations are given for conducting viral isolation for SARS-CoV. **Therefore, respiratory virus cultures of patients suspected of having H5N1 or SARS-CoV infection should not be offered or performed in laboratories without BSL3+ facilities.** It is recommended that testing be performed by PCR assays only and will be performed at MDCH on patients with suspect influenza A (H5N1) or SARS-CoV infections meeting the following criteria:

### **Testing for influenza A (H5N1)**

For <b>hospitalized</b> patients with:	For <b>ambulatory</b> patients with:
a. radiographically confirmed pneumonia, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, <b>AND</b> b. history of travel within 10 days of symptom onset to a country with documented H5N1 avian influenza in poultry and/or humans. (Currently Cambodia, China, Hong Kong, Indonesia, Japan, Korea, Laos, Thailand and Vietnam)	a. Documented temperature of >38°C (>100.4°F), <b>AND</b> b. one or more of the following: cough, sore throat, shortness of breath, <b>AND</b> c. history of contact with domestic poultry (e.g., visited a poultry farm, household raising poultry, or bird market) or a known or suspected human case of influenza A(H5N1) in an H5N1-affected country within 10 days of symptom onset. (See countries specified under hospitalized patients)

### **Severe Acute Respiratory Syndrome (SARS)**

CDC continues to recommend consideration of testing for SARS-CoV in patients who require hospitalization for radiographically confirmed pneumonia or ARDS without identifiable etiology **AND** who have one of the following risk factors in the 10 days before the onset of illness:

- Travel to mainland China, Hong Kong, or Taiwan, or close contact with an ill person with a history of recent travel to one of these areas, **OR**
- Employment in an occupation associated with a risk for SARS-CoV exposure (e.g., health care worker with direct patient contact; worker in a laboratory that contains live SARS-CoV), **OR**
- Part of a cluster of cases of atypical pneumonia without an alternative diagnosis.
- For patients with pneumonia or ARDS who have recently traveled to Guangdong Province, China, diagnostic testing for SARS-CoV should be performed immediately at a public health laboratory. For other patients, diagnostic testing should proceed as outlined in the guidance issued for use in the absence of SARS transmission worldwide.

**Specimens from persons meeting the above clinical and epidemiological criteria should be sent to MDCH for PCR testing using reagents and methods validated by the CDC.** Appropriate specimens for both agents include sputum, BAL, NP swab, aspirate or wash (nasal swab is not acceptable), oropharyngeal swab, tracheal aspirate and pleural fluid. While PCR testing for SARS-CoV is available commercially, preliminary positive results received from non-public health labs must be retested at MDCH BOL and will not be used to determine if the patient meets the epidemiological case definition. Clinical laboratories should save an aliquot of samples sent to commercial or reference laboratories or alternatively collect multiple new samples from the patient to submit to MDCH BOL. Contact MDCH Bureau of Epidemiology at 517-335-8165 (517-335-9030 after hours) to arrange for testing **before submitting specimens.**

Because the clinical presentation and travel history of persons with influenza A (H5N1) and SARS-CoV infection may overlap, use of commercially available rapid diagnostic tests for influenza may be problematic. While a positive result might rule-out SARS-CoV, we also expect these tests would be positive with influenza A H5N1. Furthermore, sensitivity of these tests may not always be optimal, leading to false-negative results. These limitations should be kept in mind when using rapid tests on patients with these risk factors.

We appreciate your assistance in sharing this information with the medical staff in your communities. We will continue to provide updated information as it becomes available. Please contact us if we can be of any assistance.

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